

**CLIENT NUMBER:**

**SECTION 1 – APPLICANT/PATIENT INFORMATION**

First name	Last name
Street number	Street address
Apartment number	City/Town
Province	Postal code
Phone number	

**SECTION 2 – CONSENT AND RELEASE FROM APPLICANT/PATIENT**

I understand that The Regional Municipality of York requires the requested personal health information to determine my eligibility for an additional bedroom in a rent-geared-to-income (RGI) unit.

By this consent, I am hereby authorizing \_\_\_\_\_ (physician’s name) to disclose the information requested on this form to the Community Services and Housing Department, The Regional Municipality of York.

I hereby consent to The Regional Municipality of York collecting this information for the purpose stated above.

Patient Signature	Date (mm/dd/yy)
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**SECTION 3: IMPORTANT NOTE TO PHYSICIANS**

Your patient is requesting an additional bedroom in rent-geared-to-income (subsidized) housing. Your patient may qualify if:

- Spouses cannot share a bedroom due to a disability or medical concern
- Additional space is required to store medical equipment needed because a member of the household has a disability or significant medical condition.

**Please complete the following sections.**

1. Does your patient have a medical condition that will adversely affect the health of one or both spouses by sharing a bedroom?

Yes            No

If yes, please explain how separate bedrooms would improve the patient’s prognosis.

**SECTION 3: IMPORTANT NOTE TO PHYSICIANS**

2. As a result of the medical condition, does the patient require space to store medical supplies or equipment?

Yes                  No

If yes, please check the boxes that apply:

- |                      |                         |
|----------------------|-------------------------|
| Commode chair        | Scooter                 |
| Oxygen tanks         | Walker                  |
| Hover lift           | Wheelchair              |
| Nebulizer/compressor | Other (please explain): |

**SECTION 4: PHYSICIAN'S DECLARATION**

I hereby certify that this information represents my best professional judgment and is true and correct to the best of my knowledge.

Physician's Name (printed)

Street number                  Street address

Apartment number                  City/Town

Province                  Postal code

Phone number

Physician's signature                  Date

**PHYSICIAN'S  
STAMP**

NOTICE: In accordance with s.29(2) of the Municipal Freedom of Information and Protection of Privacy Act and s.18(1) of the Personal Health Information Protection Act, 2004, personal information on this form is being collected under the legal authority of the Housing Services Act, 2011 for the principal purpose of determining the applicant's eligibility for housing units. If you have questions about this collection, please contact the Manager, Housing Access, The Regional Municipality of York, at 17150 Yonge Street, Newmarket, Ontario, L3Y 8V3 or phone 1-877-464-9675 ext. 72470.